STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		FCL032141	B. WING		03/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PRESTIC	SE FAMILY CARE HO	MF .	RBORN DRI NC 27703	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	Report by Randy Ju	ılian / Glenn Hoppin			ļ	
	Survey on March 12 PM . DHSR records licensed on June 8, for six (6) ambulato and respond without assistance during a Based on this we at compliance with the 10A NCAC 13G for 2009 North Carolina Building Code - Section 13 Period At the time of our visit of the section 14 PM At the time of our visit of the section 15 PM The section 15	a Section conducted a Biennial 1, 2016 from 11:30 AM to 1:00 indicate the home was first 2010 as a Family Care Home ry Residents (able to evacuate at any physical or verbal fire or other emergency). The requiring the home to be in a following: the 2005 Rules Family Care Homes and the a State Building Code - Cation 421.2 Residential Care disit, we cited deficiencies that tole plan of correction. They				
C 117	SECTION .0300 - T	And Fire Safety Approvals THE BUILDING 02 DESIGN AND	C 117			
	(n) The home sha fire and building sat	Il have current sanitation and fety inspection reports which in the home and available for				
	sanitation inspectio Provide copies of the	et as evidenced by: e survey the current fire and n reports were not available. ne most recent approved fire ection reports to this office.				
C 174	Building Equipment	Maintained Safe, Operating	C 174			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		FCL032141	B. WING		02/4	4/2046	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STATE, ZIP CODE	03/1	1/2016	
		3217 DFA	RBORN DRI				
PRESTIC	SE FAMILY CARE HO	DURHAM	, NC 27703				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
C 174	Continued From pa	ge 1	C 174				
	EQUIPMENT (a) The building at mechanical, and plucare home shall be operating condition (j) This Rule shall family care homes. This Rule is not med 1. At the time of the	and all fire safety, electrical, umbing equipment in a family maintained in a safe and apply to new and existing et as evidenced by:					
	damaged areas. Ha repaired as needed	I of leaves and some had ave the gutters cleaned and I. Provide documentation to of photos when complete.					
	the there were no h Have a qualified tec handrails. Provide of	e survey it was observed that handrails on the back deck. chnician install the required documentation to this office by eccipts when complete.					
	wooden deck, ramp complete handrails install handrails on include deck, walky	rvey it was observed that the o and walkway does not have . Have a qualified technician all elevated surfaces which way, and ramp. Provide his office in the form of photos					
	several boards on t Have a qualified tec Provide documenta photos and service	e survey it was observed that he rear deck were rotted. chnician repair/replace. tion to this office by form of order when complete.					
	the crawl space do	e survey it was observed that or was rotten. Replace the nd provide documentation to					

Division of Health Service Regulation

STATE FORM 5899 5MC621 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
		FCL032141	B. WING		03/1	1/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE			
PRESTIC	SE FAMILY CARE HO	MF	RBORN DRI	VE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
C 174	6. At the time of the there was a missing on the right side of technician make the documentation to the service order when 7. At the time of the there were flammal fluid) stored in laur removed during the propane and lighter laundry room at any to this by photo who 8. At the time of the the skylight had leasurrounding ceiling repair the leak and existing. Provide d form of photo and so 9. At the time of the the floor covering who locations around the technician replace this office by form of when complete. 10. At the time of the two of the homes find the homes find the homes find the document of the two of the homes find the document of the homes find the document of the homes find the	of photos when complete. e survey it was observed that g downspout from the gutter the home. Have a qualified e necessary repairs. Provide his office by form of photos or complete. e survey it was observed that ble items (propane and lighter hory room. These were e survey. Flammable items (fluid) can not be stored in y time. Provide documentation	C 174	DEFICIENCY			

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		FCL032141	B. WING		02/4	1/2016
NAME OF			<u> </u>	STATE, ZIP CODE	03/1	1/2016
	PROVIDER OR SUPPLIER	3217 DFA	RBORN DRI			
PRESTIC	GE FAMILY CARE HO	ME DURHAM	, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 174	Continued From pa	ge 3	C 174			
	a smoke detector in was on hand as a r installed at the time technician install th	ne survey it was observed that in the hall was missing. One eplacement but had not been to of our visit. Have a qualified the smoke detector. Provide his office by the form of photo en complete.				
	floor was soft and is bathroom. Have a c rotting material with	urvey it was observed that the s rotting in the center qualified technician replace the new. Provide proof of the service order to this office				
	there was an electr bathroom. Have a outlet. Provide docu	ne survey it was observed that ical outlet loose in the center qualified technician repair the umentation by form of photo or soffice when complete.				
	the middle bedroon preventing emerge window must remai all times for emerge items from in front	ne survey it was observed that in window was blocked incy egress. a minimum of one in operable and accessable at ency egress. Remove the of window to maintain egress. Ition to this office by form of ete.				
	while in the attic se damaged. Have a c make the necessar	nis office by form of photo and				
	the attic was being	ne survey it was observed that utilized for storage. Attics can rage, all items must be				

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C 174	Continued From pa	ge 4	C 174			
	removed. Provide of form of photo when	documentation to this office by complete.				
	the attic heat detect not properly wired a circuits when active alarm technician che detector. Provide dephotos and service 18. At the time of the Have a qualified tech documentation to the service order when 19. At the time of the there was lint and the behind the dryer and this office by form of the refrigerator door technician repair/re	ne survey it was observed that rash behind the dryer. Clean and provide documentation to of photo when complete. the survey it was observed that it is rusted. Have a qualified place door. Provide his office by form of photos				

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